

**ATTACHMENT**  
**C**  
**PART 7**

LAKE COUNTY ADULT DETENTION FACILITY  
MEDICAL DIVISION  
104 E. Erie Street  
Painesville, Ohio 44077

CONSENT FOR RELEASE OF INFORMATION  
TO INCLUDE DRUG AND/OR ALCOHOL ABUSE

I hereby authorize FMC Rochester Mann (Mago Clinic) to release  
information from the records of SHERRS, KWIN  
name  
294-80-1228 8-22-70  
S.S.N. D.O.B.

The information to be released to The Lake County Adult Detention Facility/Dr. Baster for the purpose of treatment.

The information to be released is (itemized portions of record and time period)  
Discharge/Treatment Summary, Medication, Recommendations, Appropriate Lab and/or  
Xray Reports

1UP, uriology report

I also understand that this consent is revocable upon written request to the extent that the action has been taken in reliance thereon, and the this consent will remain in force a reasonable time on order to effectuate the purpose for which it is given. (THIS AUTHORIZATION WILL BE IN EFFECT FOR 90 DAYS)

Signature

Date

Witness

Date

## HIV COUNSELING DOCUMENTATION

## POST-TEST: Seronegative

- X   1. Explain purpose of session.
- X   2. Review confidentiality.
- X   3. Test Information
- X   a. Inform patient of negative test result.
- X   b. Explain purpose of test.
- C   c. Identify remaining risks.
- X   d. Explain inability of test to detect early infections. (*false negatives*)
- X   4. Explain risk reduction behaviors (*high risk*)
- X   5. Discussed follow-up testing (*high risk*)
6. Give additional education material if requested.
- X   7. Patient Reactions/Level of Understanding/Comments

I understand the above information.

Kevin L. Siggers  
Signature of Inmate

M. Anderson  
Signature of Staff Counselor

4/8/98  
Date

\*\*\*\*\*

## Seropositive Post-Test Counseling

1. Confidentiality review.
- 2   Patient informed of results of test by physician.
- 3   Patient referred to the psychology department for follow-up counseling.

51627-060

DOB 08-22-1970  
FMC ROCHESTER, MN  
Signature of Inmate

Signature of Staff Counselor

Date

U.S. DEPARTMENT OF JUSTICE  
Federal Bureau of Prisons

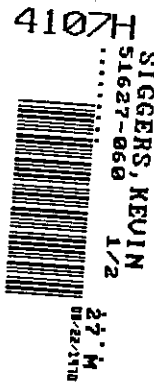
# HIV COUNSELING DOCUMENTATION

## Directions:

Use the following criteria to counsel the patient who is tested for the **HIV** antibody. Check off each item as they are discussed. Write NA beside any item that is inappropriate to the situation. Secure this form until pre- and post-test counseling is completed, then file this form in the patient's chart, documenting in the progress notes that counseling was completed as provided on forms BP-490 (61), BP-491 (61), and BP-492 (61) as appropriate.

## PRE-TEST:

1. Explain purpose of session. **SIGGERS**
2. Explain confidentiality. **KEVIN L**
3. Explain **HIV** antibody test. **B/M/O/08-22-1970** **51627-060**  
**HT/601** **WT/230** **HR/BK** **EY/BN**  
**CUSTODY/IN**
- a. What AIDS is
- b. What the test is
- c. Test Procedure
- d. Meaning of test results
- e. Inability to detect early infections (*false negatives*.)
- f. Possibility of false positives
- g. Possible need for additional testing
- h. Complications and consequence of a positive test.
4. List risk factors.
5. Explain prevention recommendations for persons with possible exposure.
6. Obtain informed consent (*when applicable*).
7. Risk Reduction Behaviors. Educational material provided.
8. Patient Reactions/Comments.



Inmate Name: \_\_\_\_\_

Register Number: \_\_\_\_\_

I understand the above information about the **HIV** test.

*Kevin L. Siggers*  
Signature of Inmate

*Lang King FWH*  
Signature of Staff Counselor

3/20/06  
Date

**MEDICAL DUTY STATUS CHECKLIST  
FEDERAL MEDICAL CENTER  
ROCHESTER, MINNESOTA**

<input type="checkbox"/> ALLRG/WOOL	<input type="checkbox"/> LIMIT SUN	<input type="checkbox"/> SOFT SHOES
<input type="checkbox"/> ART LIMB	<input type="checkbox"/> LOWER BUNK	<input type="checkbox"/> SPEC DIET
<input type="checkbox"/> ATH RESTR	<input type="checkbox"/> NO DRIVING	<input type="checkbox"/> STAND RSTR
<input type="checkbox"/> BED BOARD	<input type="checkbox"/> NO F/S	<input type="checkbox"/> SUIC WATCH
<input type="checkbox"/> COLD/WIND	<input type="checkbox"/> NO DUTY	<input type="checkbox"/> EFFECTIVE DATE
<input type="checkbox"/> DRIV RESTR	<input type="checkbox"/> NO POLLUT	<input type="checkbox"/> DELETE DATE
<input type="checkbox"/> HEAR RESTR	<input type="checkbox"/> NOT MED CL	<input type="checkbox"/> WGT 15 LB
<input type="checkbox"/> HGT RESTR	<input type="checkbox"/> ORTH SHOES	<input type="checkbox"/> WGT 20 LB
<input type="checkbox"/> HUNGR STRK	<input checked="" type="checkbox"/> REG DUTY <i>reg not med ok</i>	<input type="checkbox"/> WGT 25 LB
<input type="checkbox"/> EFFECTIVE DATE	<input type="checkbox"/> REG DUTY W	<input type="checkbox"/> WIRED JAW
<input type="checkbox"/> DELETE DATE	<input type="checkbox"/> SMOKE FREE	

REGULAR DUTY WITH - NEEDS TO BE USED WHEN ANY OTHER DUTY STATUS IS ASSIGNED.

STAMP INMATE CARD HERE:

*Siggers, Kevin*  
*51627-060*

SIGGERS, KEVIN L

51627-060

DOB 08-22-1970  
FMC ROCHESTER, MN

*Louis S. Sterling PA-C*  
SIGNATURE  
Louis S. Sterling, PA-C  
FMC Rochester, MN

SIGNATURE STAMP

*4/7/98* *1/2*  
DATE

*done 4-7-98*  
*HL*

**MEDICAL DUTY STATUS CHECKLIST  
FEDERAL MEDICAL CENTER  
ROCHESTER, MINNESOTA**

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<input type="checkbox"/> ART LIMB	<input type="checkbox"/> LOWER BUNK	<input type="checkbox"/> SPEC DIET
<input type="checkbox"/> ATH RESTR	<input type="checkbox"/> NO DRIVING	<input type="checkbox"/> STAND RSTR
<input type="checkbox"/> BED BOARD	<input type="checkbox"/> NO F/S	<input type="checkbox"/> SUIC WATCH
<input type="checkbox"/> COLD/WIND	<input type="checkbox"/> NO DUTY	_____ EFFECTIVE DATE
<input type="checkbox"/> DRIV RESTR	<input checked="" type="checkbox"/> NO POLLUT	_____ DELETE DATE
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<input type="checkbox"/> HGT RESTR	<input type="checkbox"/> ORTH SHOES	<input type="checkbox"/> WGT 20 LB
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_____ EFFECTIVE DATE	<input type="checkbox"/> REG DUTY W	<input type="checkbox"/> WIRED JAW
_____ DELETE DATE	<input type="checkbox"/> SMOKE FREE	

REGULAR DUTY WITH - NEEDS TO BE USED WHEN ANY OTHER DUTY STATUS IS ASSIGNED.

STAMP INMATE CARD HERE:

SIGGERS  
KEVIN L 51627-060  
B/M/O/08-22-1970  
HT/601 WT/230 HR/BK EY/BN  
CUSTODY/IN

*Gary J. Kunz* 3/26/98  
SIGNATURE

Gary J. Kunz, FNP-C  
FMC Rochester, MN

SIGNATURE STAMP

DATE

3/26/98

*DJ*  
3/30/98

# INMATE DISABILITY REPORTING FORM

INMATE NAME: \_\_\_\_\_ REG. NO.: \_\_\_\_\_ UNIT: \_\_\_\_\_

A disability refers to a permanent mental or physical impairment or condition that substantially limits one or more major life activities.

Please check the appropriate MDS and accomodation assignment(s):

☒ No disability identified at this time

## Speech impairment

☐ None needed SPCH - NO AC  
☐ Communication, P SPCH - COM P  
☐ Program, P SPCH - PGM P  
☐ Communication, U SPCH - COM U  
☐ Program, U SPCH - PGM U  
☐ Communication, N SPCH - COM N  
☐ Program, N SPCH - PGM N

## Vision impairment

☐ None needed VISN - NO AC  
☐ Communication, P VISN - COM P  
☐ Program, P VISN - PGM P  
☐ Communication, U VISN - COM U  
☐ Program, U VISN - PGM U  
☐ Communication, N VISN - COM N  
☐ Program, N VISN - PGM N

## Non-paralytic orthopedic impairment

☐ None needed ORTH - NO AC  
☐ Architectural, P ORTH - ACC P  
☐ Program, P ORTH - PGM P  
☐ Architectural, U ORTH - ACC U  
☐ Program, U ORTH - PGM U  
☐ Architectural, N ORTH - ACC N  
☐ Program, N ORTH - PGM N

## Complete paralysis

☐ None needed TPAR - NO AC  
☐ Architectural, P TPAR - ACC P  
☐ Program, P TPAR - PGM P  
☐ Architectural, U TPAR - ACC U  
☐ Program, U TPAR - PGM U  
☐ Architectural, N TPAR - ACC N  
☐ Program, N TPAR - PGM N

Other physical impairment (permanent limitation of activity due to disease, including mobility, heart disease, car

☐ None needed PHYS - NO AC  
☐ Architectural, P PHYS - ACC P  
☐ Program, P PHYS - PGM P  
☐ Wheelchair, P PHYS - WCH P  
☐ Architectural, U PHYS - ACC U  
☐ Program, U PHYS - PGM U  
☐ Wheelchair, U PHYS - WCH U  
☐ Architectural, N PHYS - ACC N  
☐ Program, N PHYS - PGM N  
☐ Wheelchair, N PHYS - WCH N

## Hearing impairment

☐ None needed HEAR - NO AC  
☐ Architectural, P HEAR - ARF P  
☐ Program, P HEAR - PGM P  
☐ Architectural, U HEAR - ARF U  
☐ Program, U HEAR - PGM U  
☐ Architectural, N HEAR - ARF N  
☐ Program, N HEAR - PGM N

## Missing extremities

☐ None needed EXTR - NO AC  
☐ Architectural, P EXTR - ACC P  
☐ Program, P EXTR - PGM P  
☐ Architectural, U EXTR - ACC U  
☐ Program, U EXTR - PGM U  
☐ Architectural, N EXTR - ACC N  
☐ Program, N EXTR - PGM N

## Partial Paralysis

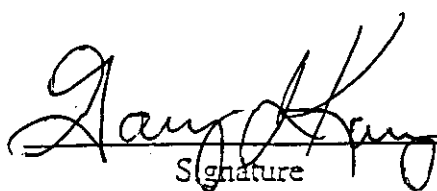
☐ None needed PPAR - NO AC  
☐ Architectural, P PPAR - ACC P  
☐ Program, P PPAR - PGM P  
☐ Architectural, U PPAR - ACC U  
☐ Program, U PPAR - PGM U  
☐ Architectural, N PPAR - ACC N  
☐ Program, N PPAR - PGM N

## Disfigurement

☐ None needed DISF - NO AC  
☐ Architectural, P DISF - ACC P  
☐ Program, P DISF - PGM P  
☐ Architectural, U DISF - ACC U  
☐ Program, U DISF - PGM U  
☐ Architectural, N DISF - ACC N  
☐ Program, N DISF - PGM N

Addressograph Here

SIGGERS  
 KEVIN L 51627-060  
 B/M/O/08-22-1970  
 HT/601 WT/230 HR/BK EY/BN  
 CUSTODY/IN

  
 Signature

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 FMC Rochester, MN

Signature Stamp

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